New York State Nurses Association
N Y S N A
Benefits Fund
PO Box 12430
Albany, NY 12212-2430
Phone: (877) RN BENEFITS
Fax: (518) 869-2317
disability@rnbenefits.org

Notice and Proof of Claim for Disability Benefits

1. Complete this form only if you become sick or disabled while employed, or if you become sick or disabled within four weeks after termination of employment. If you become sick or disabled after having been unemployed more than four weeks, use green claim form DB-300.
2. Complete all items in Part A, "Claimant's Statement." Be accurate. Check all dates.
3. Date and sign the bottom of this side of the form. If you cannot sign the claim form, a representative may sign on your behalf, but the representative must include his/her address and relationship to you.
4. Bring this form to your doctor and ask him/her to complete all items in Part B, "Doctor's Statement."
5. Bring this form to your employer and ask him/her to complete all items in Part C, "Employer's Statement."
6. When all parts of the form are filled in, mail, fax, or e-mail the claim form to the Benefits Fund within 30 days after you become sick or disabled.

Part A - Claimant's Statement

1. Full Name _____ 2. Social Security Number _____

3. Address _____ City _____ State _____ ZIP_____

Home Telephone (_____) _____ 4. Age _____ 5. Date of Birth _____ Married: ❒ Yes ❒ No

6. I became disabled on _____. My disability is (if injury, also state how, when, and where it occured) _____

_____. 7. I worked on that day: ❒ Yes ❒ No

I ❒ have ❒ have not worked since becoming disabled. if you have worked, please list dates you worked: _____

8. Please list all employers you've worked for during the 8 weeks prior to your disability:

Employer Information			Dates of Employment From Through		Regular Weekly Compensation (include all differentials, but no overtime, bonuses, or special allowances)
Name	Address	Phone No.	Mo. Day Yr.	Mo. Day Yr.	

9. My position title was _____

10. For the disability period covered by this claim, a) Are you receiving any salary or separation pay? ❒ Yes ❒ No If yes, please complete:
I have ❒ received ❒ claimed from_____ (employer name) for _____ to _____(dates).

b) Are you receiving or claiming (1) Workers' Compensation for work-connected disability? ❒ Yes ❒ No If yes, please complete:
I have ❒ received ❒ claimed from_____ (employer name) for _____ to _____ (dates).

(2) Are you receiving or claiming damages for personal injury (no-fault, etc.)? ❒ Yes ❒ No If yes, please complete:
I have ❒ received ❒ claimed from_____ (company name) for _____ to _____ (dates).

(3) Are you receiving or claiming Unemployment Insurance Benefits? ❒ Yes ❒ No If yes, please complete:
I have ❒ received ❒ claimed from_____(company name) for _____ to _____ (dates).

11. If you have received disability benefits for another period or periods of disability within the 52 weeks immediately before your present disability began, please complete: I have been paid by _____(company name) for _____ to _____ (dates).

I have read the instructions above. I hereby claim disability benefits and certify that for the period covered by this claim, I was disabled, and that the foregoing statements, and any accompanying statements are, to the best of my knowledge, true and complete.

Sign here

_____ (Signature) _____ (Date)

Representative's Address _____

Representative's Relationship _____

For Benefits Fund office use only

Pay _____ Weeks _____ Days _____

Reject _____

Certified by _____ Date _____

Part B - Doctor's Statement (please type)

1. Claimant's Name _____ 2. Age _____ 3. ❒ Female ❒ Male
4. Diagnosis/Analysis _____ Diagnosis Code _____
   a) Claimant's Symptoms _____ Objective Findings _____
5. Was claimant hospitalized? ❒ Yes ❒ No From _____ (date) to _____ (date)
6. Was an operation indicated? ❒ Yes ❒ No a) Type _____ Procedure Code _____ b) Date _____
7. a) Date of your first treatment for this disability _____. b) Date of your most recent treatment for this disability _____.
   c) Date claimant was unable to work because of this disability _____.
   d) Date claimant will be able to perform usual work (please provide an estimated approximate date) _____.
8. If claimant's disability is caused by or has arisen in conjunction with pregnancy, please provide estimated delivery date _____.
9. In your opinion, is this disability the result of an injury arising out of and in the course of employment or occupational disease?
   ❒ Yes ❒ No If yes, has Form C-4, C-4C, or C-4P been filed with the Board? ❒ Yes ❒ No
   Remarks: (please attach additional sheet if necessary) _____
10. I am physician/podiatrist/chiropractor/dentist (please circle one) licensed in the state of _____
    Doctor's Signature_____License Number _____ Date _____
    Doctor's Name (please type) _____ Phone Number _____
    Office Address _____ City _____ State _____ ZIP _____

Part C - Employer's Statement (please type)

1. Employee's Name _____ 2. Social Security Number _____
3. Date of Employment _____ Position Title _____
4. Actual last date employee worked prior to disability _____ a) Date full sick time paid to _____.
5. If employee has returned to work, give date of return _____ 6. If not yet returned to work, do you expect to rehire? ❒ Yes ❒ No
7. Did disability occur as a result of employment? ❒ Yes ❒ No If yes, please explain _____
8. Please list employee's compensation for last eight weeks prior to disability:

Week No.	Week Ending			No. of Days Worked	Regular Compensation	Week No.	Week Ending			No. of Days Worked	Regular Compensation
	Month	Day	Year				Month	Day	Year		
1						5					
2						6					
3						7					
4						8					

9. Employee's usual days worked: ❒ Monday ❒ Tuesday ❒ Wednesday ❒ Thursday ❒ Friday ❒ Saturday ❒ Sunday
10. Has employee made a claim for disability benefits in the past 52 weeks? ❒ Yes ❒ No If yes, please provide the date _____.
11. Is claimant an ❒ Employee? ❒ Other? If other, please explain _____.
12. If employee is no longer employed by you, check reason for separation:
    ❒ Fired (Please provide reason) _____
    ❒ Resigned (Please provide reason)_____
    ❒ Other (Please explain) _____
13. Name of Workers' Compensation carrier: _____
14. Did employee receive Unemployment Insurance Benefits within eight weeks prior to disability? ❒ Yes ❒ No If yes, date: _____
15. Does the employee work for anyone other than you? ❒ Yes ❒ No If yes, please explain _____

Your Name _____ Title _____ Signature _____

Employer Name _____ Employer Code Number _____

Address _____ City _____ State _____ ZIP _____

Telephone Number _____ Date _____

When Parts A, B, and C are completed, mail to NYSNA Benefits Fund, PO Box 12430, Albany, NY 12212-2430, fax to(518) 869-2317, or scan and e-mail to disability@rnbenefits.org.